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AIDS ALERT®

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Guarding HIV-positives against vaccine reaction in the age of bioterror

Scant medical data spur policy debate

Four days before President **George W. Bush** announced a national smallpox vaccination plan last month, a group of public health experts heaved a sigh of relief. In a meeting with Vice President **Dick Cheney**, they had finally managed to convince the administration not to follow a policy of mass, pre-emptive smallpox inoculation.

Those experts had argued that that a policy of mass inoculation of all Americans could produce casualties to HIV-infected people and others with damaged immune systems that would far outweigh any gains to be made from inoculations, at least in the absence of a clear terrorist threat.

"If this were a vaccine free of adverse events, the discussion would be moot," says **Anthony Fauci**, MD, director of the National Institute of Allergy and Infectious Diseases (NIAID). "But it's the most dangerous vaccine we have, and the adverse events from it are well-known."

Calculating the risks of widespread serious reactions from smallpox vaccinations is devilishly hard, because most data on the subject predate the era of AIDS. With so many more people living today with suppressed immune systems, some experts fear there will be more serious problems associated with the vaccine than in the past.

Also worrisome is the way that recently vaccinated people shed virus from their vaccine site for up to four weeks. That means they can inadvertently infect others, in a phenomenon known as

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AIDS Alert International

Prevention efforts yield some hope for future

Prevention continues to offer the best hope for stopping the AIDS epidemic, and recent success stories in South Africa and Uganda prove that prevention works, according to a recent report 22

Dallas organization shows caring counts

For an AIDS organization to succeed in attracting at-risk populations, it must demonstrate that it cares about the clients and accepts them as they are, says a long-time HIV/AIDS activist who has succeeded where others have failed. Renaissance III is a community center for young African-American men who have sex with men, and it is working 25

COMING IN FUTURE ISSUES

■ The President's proposed HIV/AIDS budget: Here's a look at the HIV funding battle ahead

■ ADAPs faltering in some states: Long waiting lists, restrictions, and other problems cited as result of cash-poor state governments, stingier federal government

■ Retrovirus conference coverage: Here's a look at the latest scientific and pharmaceutical news coming from investigators and NIH

■ HIV vaccine update: Vaccine research continues around the world, but how close are we to a vaccine solution?

■ AIDS attention waning on world stage: Can the long-term battle to conquer the world's most insidious epidemic hold the interest of wealthy nations at war against terrorism and biological warfare threats?

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contact vaccinia.

The key, experts say, is to carefully screen vaccination volunteers for HIV and cover the vaccination site with an occlusive dressing. By taking those steps, most problems with serious reactions and contact vaccinia can be avoided.

Still, as one hospital executive says, someone's occlusive bandage is bound to fall off, and someone with advanced HIV is bound to be vaccinated by mistake.

That's part of the difficult calculus public health experts must perform as they weigh one unknown — the extent of vaccine complications — against an even bigger unknown, the scope of a bioterrorist threat.

"It's a delicate balancing act," says **Julie Gerberding**, MD, MPH, director of the Centers for Disease Control and Prevention in Atlanta. "The more people we immunize, the more deaths and life-threatening complications we are going to see. We have a risk of smallpox, but we can't really quantify it."

Who's at risk?

By Fauci's estimate, for every million people vaccinated, there will be at least one to two deaths; 15 to 50 life-threatening complications; and up to 900 serious but non-life-threatening complications. Complications range from the widespread but merely unpleasant to the rare but often fatal.

By some estimates, as many as 60 million people in the United States are at risk for serious side effects from the vaccine. According to the CDC, these risk groups include:

— the 506,154 U.S. residents known to be living with HIV, as well as an estimated 300,000 more who are infected but don't know it;

— pregnant women and nursing mothers;

— children less than 12 months old;

— the 1.2 million people diagnosed each year with non-skin cancers;

— the 2.1 million people with rheumatoid arthritis treated with corticosteroids;

— the tens of thousands of recipients of bone-marrow and solid-organ transplants who are receiving immunosuppressive therapy;

— the nation's 14 million asthma sufferers, some of whom use steroids intermittently;

— the 15% of the population that either has atopic dermatitis (also known as eczema) or that has a history of the condition. At similar risk are others with skin disorders, including burns, shingles, severe acne, impetigo, or chickenpox;

— tens of thousands of newborns and patients on intensive care wards.

When people are vaccinated for smallpox, even those in perfectly good health should expect to suffer from several nuisance-type reactions. Almost everyone will have a sore, itchy arm at the vaccination site. In recent trials of Dryvax, the vaccine that will be used in the first wave of inoculations, half the subjects got muscle aches, says Fauci. About one in 10 had fever. A third of recipients felt so bad they skipped work or otherwise cut back on daily activities for a day or so.

The biggest threat: Progressive vaccinia

None of these, of course, are big worries for those with healthy immune systems. For these people, the most common complication to be feared is progressive vaccinia (also known as vaccinia necrosum and vaccinia gangrenosum).

In this condition, lesions at the original inoculation site expand and spread to other sites, and vaccinia virus proliferates in the skin, internal organs, and bloodstream. Patients must be hospitalized and treated with surgical debridement.

Though the condition is often fatal, optimal therapy probably consists of highly active antiretroviral therapy and vaccinia immune globulin (VIG), with perhaps cidofir thrown in for good measure, says **John Bartlett**, MD, director of the Department of Infectious Diseases at the Johns Hopkins University School of Medicine in Baltimore, and a senior core faculty member of the school's Center for Civilian Biodefense Strategies.

Supplies of VIG (which is recovered from the blood of someone who has received the smallpox vaccine) are currently limited to about 600 doses, but more should become available once the vaccination program gets under way.

Because smallpox vaccination of the American public was halted in 1972, before various groups of people living with some degree of immune impairment became relatively common, there are few cases of progressive vaccinia recorded in medical literature. Probably because inactivated vaccinia virus often is a vector of choice for experimental AIDS vaccines, there are a handful of other instances where progressive vaccinia led to the death of HIV-infected people.

By reaching back to the pre-AIDS era, it's also possible to find a few reports of people with compromised immune systems who contracted progressive vaccinia.

Good advice for immune-compromised patients

No pre-emptive vaccination for HIV-positives

Because comprehensive scientific data are lacking, health experts can only conjecture about the possible ramifications of smallpox vaccinations on people with HIV and AIDS. Here is the advice most experts are offering:

- Anyone who plans to volunteer to be vaccinated for smallpox should know their HIV status. Pre-emptive vaccination is not recommended for HIV-positive people, nor for the partner of someone who is HIV-positive.
- HIV testing, though not mandatory, should be made available to anyone who asks for it. Rapid tests (SUDS, OraQuick), if available, are preferred.
- Anyone who has close contact with a known smallpox case should be vaccinated no matter what their HIV status. "Close contact" means being within six to eight feet of a smallpox victim during period of infectiousness, which peaks once a rash appears, making it relatively easy to tell when someone is infectious. Infectiousness subsides only after scabs have fallen off.
- Patients with advanced HIV disease are probably at much greater risk for vaccine complications than those with early-stage disease. The cut-off point for "advanced disease" probably means a CD4 count less than 200/mm^3, several experts say.
- The most dreaded complication for immune-impaired people is progressive vaccinia (also known as vaccinia necrosis and vaccinia gangrenosum). During the pre-HIV era, frequency of this complication ran at less than 1 per million, with death in 90% of those cases. The frequency may prove to be higher in today's population.
- There is no cure for progressive vaccinia. Optimal therapy probably includes immune reconstitution with highly active antiretroviral therapy, coupled with vaccinia immune globulin and possibly cidofovir.
- Contact vaccinia — the inadvertent spread of vaccinia virus from the vaccination site to someone else — almost always results from direct contact. To prevent its occurrence, vaccinated persons should wash their hands with soap and water and cover the vaccination site with an occlusive dressing, a T-shirt, and long sleeves. Used bandages should be put into sealed plastic bags and discarded. Don't share used towels, bedding, or clothing.
- No matter how carefully a person covers the vaccine site, the person shouldn't share space with someone who is HIV-positive until he or she has stopped shedding virus. That means waiting 3-4 weeks until the scab at the vaccine site falls off. Vaccinated health care workers should either be furloughed until they are no longer shedding virus or be re-assigned to duties where they won't be in contact with immune-compromised patients.
- Vaccinia disease may exacerbate replication of HIV, according to findings from one case, but that isn't known as a certainty. But it is certain that being HIV-positive makes someone much more susceptible to succumbing to smallpox. So if an HIV-positive person is exposed to smallpox, he or she should get vaccinated. ■

One case that has caused concern is that of a 19-year-old military recruit. At the time he was vaccinated, in the late 1980s, he was infected with undetected HIV. As a result of the vaccination, the recruit fell sick with progressive vaccinia. He was treated with VIG, and after a complicated course of illness, he recovered. However, he died several months later of AIDS.

At about the same time, as many as 400 other military recruits with undetected HIV were also vaccinated for smallpox, but none fell sick — presumably because their immune systems were not as damaged as the first soldier's.

What does the case of the 19-year-old tell us about HIV and smallpox vaccinations? Not a thing, argue some, given that the young man died of complications due to AIDS, not the smallpox vaccine. Others contend that the case may offer not one, but two lessons: first, that immune damage caused by HIV places a person at elevated risk for progressive vaccinia; and second, perhaps, that vaccinia speeds HIV replication, hastening the onset of AIDS.

There are other possible serious side effects from the smallpox vaccine, but having an impaired immune system doesn't appear to correlate with experiencing them. These include postvaccinial encephalitis and postvaccinial

encephalopathy, two dangerous neurological complications, and eczema vaccinatum, an often-fatal complication afflicting those with active eczema or a history of eczema.

Although public health experts are generally relieved to see that the Bush plan does not call for mass pre-emptive vaccinations, many are surprised to hear the president announce that individuals who want to be vaccinated will be allowed to do so.

"I don't think the vaccine should be made available to the public any more than I think a person should be able to walk into a pharmacy and ask for tetracycline or penicillin," says **Randall Larsen**, director of the ANSER Institute for Homeland Security in Washington, DC. "If a bunch of people start taking it and you have a fifth-grader who dies, it'll be on the tube 24/7, and then people will stop taking it."

There are two other less controversial elements of the plan as well. To start with, military recruits who may see action in Iraq in the event of war will be vaccinated. As it happens, all recruits are already tested for HIV upon entry to the service, and periodically thereafter. Even so, as the military phase of the vaccine campaign cranks up, early reports have it that fully one-third of recruits are exempted from vaccination on various grounds.

"We're paying a whole lot more attention to screening," says Assistant Secretary for Defense of Health Affairs **William Winkenwarder**, comparing the current efforts to less risk-averse times.

In the final piece of the plan, the vaccine is to be offered to the nation's approximately 10 million health care workers. The half-million or so expected to volunteer for inoculation will make up the nation's "smallpox responder teams."

Some hospitals won't participate

After weighing the risks to patients and employees, some hospital administrators have decided to opt out of the first-responder plan. "I don't like to cause disease," says **Carlos del Rio**, MD, chief of medicine at Grady Memorial Hospital and an infectious disease specialist at Emory University, both in Atlanta. "If, say, a patient with AIDS became infected [with vaccinia], that would be a disaster."

At the CDC, Gerberding says she expects most hospitals will take part in the vaccination program, and adds that she isn't troubled by the decision of some not to take part.

If and when a case of smallpox is identified, the CDC strategy is first to deploy a "ring vaccination" response, that is, identifying the source case and then finding and vaccinating contacts. The plan calls for adding mass vaccinations if the initial number of cases or outbreak locations is large or if new cases fail to decline over time.

Critics of this plan argue that a broader, mass-inoculation approach would result in fewer deaths and faster epidemic eradication. They also say that in our mobile society, an epidemic could outrun the vaccinators.

As for the HIV-positive and other immune-impaired people, a strategy of inoculating everyone ahead of time leaves more room for careful screening for HIV, says **William Bicknell**, MD, from the Boston University School of Public Health. Plus, raising levels of so-called herd immunity will create a buffer for those whose damaged immune systems leave them at higher risk for smallpox. ■

HIV poses challenges for Southern states

Most people with AIDS in South are minorities

When discussions turn to HIV/AIDS, most people assume the U.S. epidemic is primarily a northeastern and western coast problem, where most of the AIDS activism and media attention are focused.

Statistics paint a different picture, one that greatly affects the availability of resources and health care services for HIV patients: The southern United States has the greatest estimated AIDS prevalence and incidence, and it's where the epidemic is increasing at the fastest rate.

"The problem in the South is the one that seems to be increasing, and the South has been the hardest hit by the epidemic," says **Jennifer Cates**, senior program officer of HIV/AIDS policy for the Kaiser Family Foundation in Washington, DC. The Henry J. Kaiser Family Foundation recently published reports about HIV/AIDS and sexually transmitted diseases (STDs) in the southern states and co-sponsored a conference, titled "Southern States Summit

on HIV/AIDS & STDs," held in November 2002 in Charlotte, NC. The Southern State AIDS Directors Work Group and National Alliance of State and Territorial AIDS Directors (NASTAD) of Washington, DC, were the conference's other sponsors.

"In the South, African-Americans have been disproportionately affected," Cates says. "African-Americans are 19% of the population but were over half of the people living with AIDS at the end of 1999."

Of the estimated 39,910 people estimated to have AIDS in the United States in 2001, an estimated 18,364 reside in the South. **(See chart on AIDS incidence, p. 23.)**

Even more alarming is the fact that the South's proportion of estimated AIDS cases has increased between 1993 and 2001, in the same period that other regions have seen decreases in their AIDS prevalence and incidence. **(See chart on regional AIDS prevalence and incidence, p. 24.)**

As the epidemic shifts south, one of the key issues is whether the nation's traditionally poorer states can handle the burden of a very costly and resource-intensive epidemic.

Some of the significant challenges in the South are the lack of health care infrastructure in certain areas and the epidemic's more rural nature, affecting impoverished people who may lack access to transportation and adequate health care, says **Julie Scofield**, executive director of NASTAD.

The recent summit was convened at the request of southern officials who wanted to share information about the shared problem of supporting comprehensive HIV treatment programs, Scofield says.

"We brought together both health department and HIV and STD officials, community folks from across the South, representatives of major federal agencies that fund HIV programs, key academic researchers, and state legislators," Scofield says. "We spent a couple of days together talking about data and unique barriers and what problems folks face in the South in accessing care."

While southern states are not uniformly similar in the scope of the HIV epidemic and their abilities to handle it, there is a common theme related to state HIV funding and health care infrastructure.

For example, the state of North Carolina has one of the nation's most serious state budget crises, which has resulted in the state's AIDS Drug Assistance Program (ADAP) being closed to new enrollees in the summer of 2002, says **Evelyn Foust**, MPH, CPM, North Carolina HIV/STD Director in the Division of Epidemiology at the state's Department of Health and Human Services in Raleigh.

"That program provides life-sustaining medications to people who don't have insurance and who don't qualify for Medicaid," Foust says. "And that was a heart-breaking and extremely disturbing set of circumstances, for us to turn away people who deserve to have access to drugs that will keep them healthier and keep them alive."

While Alabama, Kentucky, and Texas also had ADAP waiting lists in October 2002, North Carolina's list was the longest, and it represented a high number of indigent people living with HIV/AIDS. North Carolina's ADAP has an income eligibility that is among the lowest in the nation: To qualify for the program, a person's income must be no more than 125% of the federal poverty level.

Nationwide, the income eligibility criteria range up to 500% of the federal poverty level, and up to 400% in the South (in Mississippi and Maryland).

North Carolina's ADAP waiting list grew to 800 people until October 2002, when the state was able to piece together supplemental funding from federal and state sources, taking 680 people off the waiting list, Foust says.

However, anyone who became eligible for ADAP medication in North Carolina after Oct. 4, 2002, had to be added to the waiting list, Foust adds.

"We're not clear about what the funding will look like next year," Foust says. "We want to make certain people have ongoing access to medications, but the budget crisis will continue to challenge us."

Epidemic's increase outstrips resources

North Carolina provides 40% of the state's ADAP funds, treating people affected by an epidemic that is growing more rapidly than the state's infrastructure can handle. As of 2001, North Carolina ranked 15th nationwide in the prevalence of persons living with AIDS, and it ranked 11th nationwide in the number of new AIDS cases/incidence.

"I should think we are symptomatic of the problem in the South," Foust says. "We're representative of the crisis in the South in terms of

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AIDS ALERT®
INTERNATIONAL

AIDS destroying hands that rock the world's cradle

HIV infection of women in rich nations also on rise

The latest AIDS epidemic news blaring out to the international health community as 2002 drew to a close was particularly devastating because it offered strong evidence that women increasingly are infected with HIV and are dying of AIDS, and that their proportion of the epidemic's toll now is close to 50% worldwide.

"For the first time, half of the people living with AIDS globally are women, and in sub-Saharan Africa, 60% are women," says **Peter Piot**, MD, executive director of UNAIDS in Geneva, Switzerland.

In sub-Saharan Africa, the epidemic's toll on women has exacerbated the food crisis and increased the number of orphaned children. Women work on the farm, so as greater numbers of women become sick and die, the region's famine and drop in agriculture production will worsen, Piot explains.

The epidemic's impact on women has made communities less resilient, Piot says.

"They will be weaker when they start planting seeds again after the rains come back," Piot explains. "So we can count on a longer food crisis than the region is used to."

Women also are sub-Saharan Africa's foundation of the family. In these societies, the women are the ones who make certain their children are educated and who are the chief caregivers for sick family members, says **Bernhard Schwartlander**, MD, PhD, HIV/AIDS director of the World Health Organization (WHO) in Geneva.

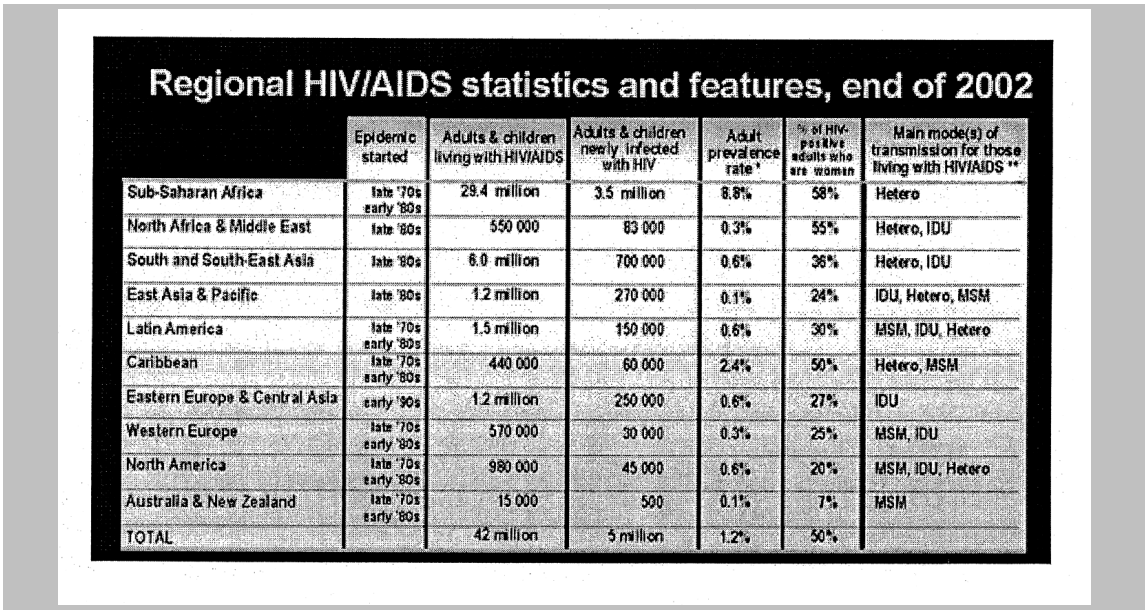
The trend of increasing numbers of infected women is particularly troublesome because it's primarily women of childbearing age, and especially very young women, who are at the greatest risk of HIV infection.

As more women, ages 20 to 45, join the ranks

Global summary of the HIV/AIDS epidemic, December 2002

Number of people living with HIV/AIDS	Total	42 million
	Adults	38.6 million
	Women	*19.2 million*
	Children under 15 years	3.2 million
People newly infected with HIV in 2002	Total	5 million
	Adults	4.2 million
	Women	*2 million*
	Children under 15 years	800 000
AIDS deaths in 2002	Total	3.1 million
	Adults	2.5 million
	Women	*1.2 million*
	Children under 15 years	610 000

Source: World Health Organization, AIDS Epidemic Update. Geneva, Switzerland; December 2002.



Regional HIV/AIDS statistics and features, end of 2002

	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate *	% of HIV-positive adults who are women	Main mode(s) of transmission for those living with HIV/AIDS **
Sub-Saharan Africa	late '70s early '80s	29.4 million	3.5 million	8.8%	58%	Hetero
North Africa & Middle East	late '80s	550 000	83 000	0.3%	55%	Hetero, IDU
South and South-East Asia	late '80s	6.0 million	700 000	0.6%	36%	Hetero, IDU
East Asia & Pacific	late '80s	1.2 million	270 000	0.1%	24%	IDU, Hetero, MSM
Latin America	late '70s early '80s	1.5 million	150 000	0.6%	30%	MSM, IDU, Hetero
Caribbean	late '70s early '80s	440 000	60 000	2.4%	50%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	1.2 million	250 000	0.6%	27%	IDU
Western Europe	late '70s early '80s	570 000	30 000	0.3%	25%	MSM, IDU
North America	late '70s early '80s	980 000	45 000	0.6%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s early '80s	15 000	500	0.1%	7%	MSM
TOTAL		42 million	5 million	1.2%	50%	

Source: World Health Organization, AIDS Epidemic Update. Geneva, Switzerland; December 2002.

of men of this age group in becoming infected with HIV/AIDS, the situation has grown into a major humanitarian crisis, Piot says.

"A chunk of that population is disappearing, and it's something we've only seen up to now after wars, and then only on the male side," Piot says. "There is a whole generation of orphans who will grow up, and that will create social instability, as well."

The lack of access to HIV treatment is a major cause of the societal breakdown, Piot adds.

"What we're seeing in Southern Africa is the first sign of the larger societywide destabilizing impact of AIDS, as was predicted some years ago, but frankly, I didn't think it would occur this fast," Piot says.

In some African countries, about twice as many young women as men are infected with HIV, according to the December 2002 AIDS Epidemic Update by UNAIDS and WHO. **(See Global Summary chart of HIV/AIDS epidemic, p. 19.)**

An estimated 6-11% of women ages 15-24 were living with HIV/AIDS in sub-Saharan Africa in 2001, whereas for young men the estimates were 3-6% living with HIV/AIDS, the report states.

The chief reason for this trend is young women having sex with older men, who are more likely than younger men to be infected, Schwartlander says.

It's also the case that young women are physically more vulnerable to HIV infection than are older women because of an immature cervix, and it's long been known that HIV transmission from man to woman is much more efficient than it is from woman to man, Schwartlander explains.

In some places, the prevalence of young women who are infected with HIV when they visit a clinic to deliver babies has climbed to 30%, Schwartlander says.

"These are shocking figures," he adds.

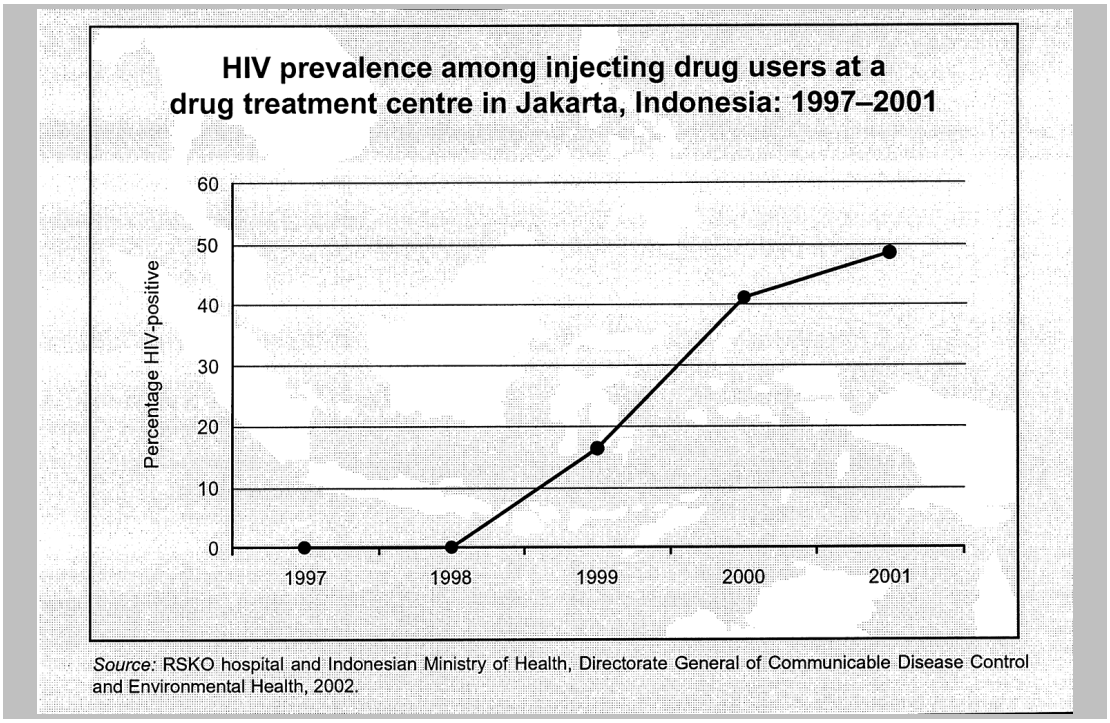
While the feminization of the AIDS epidemic is having the most devastating effect on the sub-Saharan region, it's a trend that can be seen everywhere in the world.

While Russia's HIV problem still is predominantly the result of young people who inject drugs, heterosexual intercourse is now the main mode of transmission in Belarus and Ukraine, the report notes.

"Heterosexual transmission is proportionately on the rise in every continent," Piot says. "The Ukraine has a more recent epidemic. Originally this was basically an epidemic among injection drug users [IDUs], and now their share of new infections has dropped to 56% and that of heterosexual transmission is close to 30%."

Statistics showing the rapid rise of HIV infections among Eastern European countries suggest that heterosexual transmission soon will play a larger role everywhere. **(See chart on Regional HIV/AIDS Statistics, above.)**

The 2002 UNAIDS/WHO report notes that there is evidence that young people in several



of these countries are becoming sexually active at an earlier age and that premarital sex is on the rise. At the same time, young people remain ignorant about HIV and AIDS and how the virus is transmitted.

Even in Western Europe and in other high-income countries, including the United States, the proportion of women becoming infected with HIV is on the rise. Ten years ago, the chief mode of HIV transmission in Western Europe involved men who have sex with men (MSM) and IDUs. Now, heterosexual transmission is the main mode of transmission, Piot says.

Heterosexual transmission now accounts for 59% of the new HIV diagnoses in several Western European countries. In the United Kingdom, more than half of the 4,279 new HIV infections diagnosed in 2001 were the result of heterosexual sex, compared with 33% of new infections attributed to heterosexual sex in 1998, the UNAIDS/WHO report states.

In some Western European countries, a major portion of the people infected with HIV through heterosexual sex are people who have immigrated from or have lived in areas where HIV prevalence is high, the report says.

It's not surprising that the transmission of HIV through heterosexual sex is becoming a major factor in the epidemic, because while MSMs and IDUs may spread HIV more efficiently, their total numbers are small when compared to the heterosexual population, Piot says.

However, because people in the wealthier nations have access to antiretroviral therapy, there is a steadily growing number of people living with AIDS. This group still reflects the traditional risk groups of IDUs and MSM, but that likely will change in the future as the number of infected women increases, Piot says.

Another trend that is especially noticeable in the United States, but also can be found in other high-income nations, is the preponderance of HIV infection among poor, minority, and marginalized groups, Piot says.

"African-Americans are disproportionately infected by HIV/AIDS in the United States," Piot says. "Half of the new infections are in that group that is only 13% of the U.S. population."

In some ways this trend is the result of the highly successful antiretroviral therapies that have focused attention and resources on treatment and away from prevention, Schwartlander says.

"Going back in history, you had successful programs at preventing infection among gay men and IDUs and other groups," Schwartlander explains. "But with the introduction of effective treatments to delay disease and death, there is a complete shift to care and giving drugs to people who are sick, and the elements of prevention have been almost forgotten."

So in all parts of society, there are increases in risk behaviors, increases in new infections, and increases of HIV and AIDS among women, minorities, and heterosexuals. The only sensible solution is to increase prevention efforts and spending, Schwartlander and Piot say. **(See story on successful prevention efforts, below.)**

"Far more explicit education and prevention programs should be organized," Piot says.

Western countries and societies need to be smarter in how they teach prevention, says Schwartlander.

"We need to talk the right language, the language of young people and of disadvantaged minorities," Schwartlander adds. "A lot can be done to improve the language and provide prevention to those who need it most, and we haven't done enough of that."

Until prevention efforts are overhauled and improved, the epidemic will continue to increase among women, the disadvantaged, and heterosexuals. "Every new infection that happens in a situation where we have all the resources available is one infection too many," Schwartlander says. ■

African prevention efforts yield hope for future

Small successes could be model

HIV prevention continues to offer the world's best hope in stopping the AIDS epidemic, and recent success stories in South Africa and Uganda prove that these work, according to the recent AIDS Epidemic Update report by UNAIDS and the World Health Organization (WHO) in Geneva, Switzerland.

"We should not forget that delay of infection, a delay of one year, could cause the avoidance of another five million deaths," says **Bernhard Schwartlander**, MD, PhD, HIV/AIDS director for WHO.

Prevention efforts in South Africa have resulted in a significant drop in HIV prevalence rates among pregnant women under age 20, the report says.

In 1998, that group's HIV prevalence rate was 21%, while in 2001 the HIV prevalence rate had fallen to 15.4%. Syphilis rates among pregnant women also had fallen from 11.2% in 1997 to 2.8% in 2001, according to the report, which attributes the decline to prevention efforts and education.

The report also notes that HIV infection rates continue to rise among older pregnant women.

Prevention efforts also are credited with a decline in HIV prevalence among inner-city women ages 15-24 who attend antenatal clinics in Addis Ababa, Ethiopia. The infection rate dropped from 24.2% in 1995 to 15.1% in 2001, the report says.

However, the greatest evidence of prevention's impact on HIV prevalence can be found in Uganda, where HIV prevalence among pregnant women ages 15-19 has dropped steadily in recent years. Also, condom use among single women of the same age group nearly doubled between 1995 and 2001, and there was evidence that women in that age group had delayed or abstained from sexual intercourse, the report says.

While the drops in HIV prevalence are a positive sign that prevention works, these small successes only point to a strategy — not to a blueprint — for turning the epidemic around, because the prevention programs that work with certain populations in Uganda and South Africa may not be suitable for other populations in those countries or in other nations.

There is no single prevention program that will work for all purposes, Schwartlander says.

Prevention works when it results in a mixture of postponement of first sexual intercourse, increased condom use, a decrease in sexual partners, and fewer commercial sex encounters for men, Schwartlander says.

"So it's an illusion to think one intervention will fix this epidemic, and that's one of the main messages," Schwartlander says.

Another aspect of prevention involves making testing and counseling accessible to everyone at risk in developing countries, and that goal still remains elusive in most of sub-Saharan Africa, says **Peter Piot**, MD, executive director of UNAIDS.

"Worldwide, most people who are infected don't know they're infected," Piot says. "Testing and counseling are a priority for prevention."

However, it is difficult to convince people in developing nations to be tested for HIV, even when it is available, when there is no available treatment. Thus, the world's wealthier nations need to invest more in treatment efforts among poor nations, and this will help to improve prevention, as well, Piot says. ■

AIDS Death Rate

Estimated[1] number of deaths in persons with AIDS and death rates per 100,000 population in 2000, and cumulative deaths through December 2000, by age and area of residence at death, United States

	Deaths in 2000 by age at death				Cumulative deaths through 200 by age at death		
Area of residence	**Adults/ adolescents**	**Children <13 years old**	**Total[2]**	**Death reate per 100,000**	**Adults/ adolescents**	**Children <13 years old**	**Total[3]**
Alabama	177	2	180	4.0	3,335	46	3,380
Alaska	3	0	3	0.5	255	3	258
Arizona	129	2	131	2.5	4,482	26	4,509
Arkansas	21	0	21	0.8	1,421	15	1,436
California	1,538	2	1,540	4.5	71,974	336	72,310
Colorado	113	0	113	2.6	4,059	20	4,079
Connecticut	160	0	160	4.7	5,836	96	5,932
Delaware	90	0	90	11.5	1,384	10	1,394
DC	150	2	152	26.6	7,619	110	7.729
Florida	2,101	9	2,110	13.2	43,683	751	44,434
Georgia	636	1	638	7.8	13,062	111	13,173
Hawaii	33	1	34	2.8	1,524	8	1,532
Idaho	11	0	11	0.8	308	2	310
Illinois	504	2	506	4.1	15,409	127	15,536
Indiana	117	0	117	1.9	3,593	20	3,613
Iowa	31	0	31	1.1	884	6	890
Kansas	30	0	30	1.1	1,433	6	1,439
Kentucky	55	0	55	1.4	1,894	8	1,902
Louisiana	361	1	362	8.1	7,463	63	7.706
Maine	8	0	8	0.6	592	1	593
Maryland	607	0	607	11.5	11,602	120	11,183
Massachusetts	169	3	171	2.7	8,980	116	9.096
Michigan	301	0	301	3.0	7,059	68	7,128
Minnesota	77	0	77	1.6	2,235	11	2,246
Mississippi	174	0	174	6.1	2,497	27	2,524
Missouri	181	0	181	3.2	5,079	38	5,117
Montana	4	0	4	0.4	195	5	200
Nebraska	30	0	30	1.8	679	5	684
Nevada	131	0	131	6.5	2,382	15	2,397
New Hampshire	10	0	10	0.8	468	5	473
New Jersey	1,002	6	1,007	12.0	26,272	433	26,705
New Mexico	41	0	41	2.3	1,150	1	1,151
New York	2,216	7	2,223	11.7	87.377	1,388	88,766
North Carolina	309	1	311	3.9	6,390	72	6,462
North Dakota	9	0	9	1.3	96	0	96
Ohio	137	0	137	1.2	7,444	70	7,515
Oklahoma	71	0	71	2.1	2,316	16	2,332
Oregon	92	0	92	2.7	3,019	8	3,027
Pennsylvania	388	1	389	3.2	13,882	141	14,024
Rhode Island	51	0	51	4.8	1,189	13	1,202
South Carolina	249	0	249	6.2	5,001	48	5,050
South Dakota	5	0	5	0.7	132	2	134
Tennessee	255	1	256	4.5	4,202	33	4,235
Texas	1,050	2	1,052	5.0	30.970	211	31,181
Utah	39	0	39	1.7	1,017	13	1,030
Vermont	4	0	4	0.7	234	4	238
Virginia	401	1	402	5.7	7,254	59	7,313
Washington	121	1	122	2.1	5,261	15	5,276
West Virginia	26	0	26	1.4	738	5	743
Wisconsin	101	0	101	1.9	2,196	18	2,214
Wyoming	5	0	5	1.0	100	0	100
U.S. dependencies, possessions and associated nations							
Guam	0	0	0	0.0	29	0	29
Pacific Islands US	0	0	0	0.0	5	0	5
Puerto Rico	693	5	698	18.3	16,727	213	16,940
Virgin Islands US	5	0	5	0.0	241	7	248
Total	**15,237**	**51**	**15,288**		**454,562**	**4,956**	**459,518**

[1]Data are adjusted for delays in the reporting of cases and deaths.

[2]Includes 16 cases whose area of residence at death and diagnosis is a foreign country or unknown; totals may not equal the sum of the rows or columns due to rounding.

[3]Includes 298 cases whose area of residence at death and diagnosis is a foreign counrty or unknown; totals may not equal th sum of the rows or columns due to rounding.

the escalating HIV/AIDS cases and not having enough resources to meet all of those needs."

Southern states also have the nation's greatest disproportionate share of African-Americans among their HIV/AIDS cases. Nationwide, African-Americans with HIV/AIDS as a percentage of prevalence accounted for 42% of the epidemic, according to 1999 data; in the South, that percentage was 53%.

"From what I see, African-American men who have sex with men [MSM] are at the epicenter of the HIV epidemic and the black communities across the South," says **Don Sneed**, executive director of Renaissance III in Dallas, the state's first community center for young African-American MSM.

"As you move out from the epicenter, then you find other populations that are being infected," Sneed says.

Sneed, who spoke at the southern summit about mobilizing communities, says one of the first realities that needs to be addressed in focusing prevention efforts on African-American MSM is that there is no African-American gay community. Unlike white gay communities, African-American MSM are not cohesive and connected and active politically, Sneed says.

"One thing I told people attending the southern summit is that they are trying to mobilize something that doesn't exist," Sneed says.

"In the white MSM community you see businesses, newspapers, social and political organizations, people who are vested and open with their sexuality, people who hold key positions in private organizations and public institutions, and so forth," he explains. "There tend to be sections of certain cities that are designated as the white gay area, so you have a viable community as such, and you don't have that in the African-American gay MSM community."

Sneed suggests that any HIV prevention community mobilization in the South must be done simultaneously with community building. It's this type of groundbreaking work that Renaissance III has done. **(For more information on Renaissance III, see story, p. 25.)**

Another issue that concerns southern HIV/AIDS officials is the level of stigma and discrimination that continue to exist and hamper efforts to provide effective HIV testing, counseling, and treatment.

"We have an ongoing epidemic of fear associated with the illness," Foust says. "People are concerned about issues like whether they can get

Table II
Estimated AIDS Prevalence, Incidence, & Population by Region, 2001

REGION	Population (2001)	Estimated Proportion Living with AIDS/ Prevalence (2001)	Estimated Number New AIDS Cases/ Incidence (2001)
	Percent	Percent	Percent
United States	100%	100%	100%
South	36%	40%	46%
Northeast	19%	30%	28%
West	23%	19%	16%
Midwest	23%	10%	10%

SOURCES:
Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, Vol. 13, No. 2, 2002;U.S. Bureau of the Census, Time Series of State Population Estimates, 2002.

AIDS by hugging someone or using the same utensils."

For instance, one anecdote Foust has heard concerns a North Carolina family that makes the family member infected with HIV use plastic plates and plastic forks.

"We encounter people every day who get a new diagnosis of HIV infection and who are asked to leave their family home or their church, or who are told they can't just come around anymore," Foust says.

"Stigma and discrimination occur in every place in the country, but I do think the South is particularly challenged in overcoming some of those obstacles," Foust adds. "And I think the way we need to do that is to educate people about how the virus is transmitted and how it's not."

Of course, providing such prevention and public education messages requires funding, and this, again, is where the South has barriers to reaching all of the populations that need these messages, Foust says.

While some states provide HIV education in public schools, which is a cost-effective way to reach a general populace with prevention messages, this is not as common a strategy in the South, Scofield says.

Finally, the rural nature of the southern HIV epidemic makes it difficult to match HIV-infected and at-risk people with existing prevention and treatment programs.

Foust recalls the early days of the AIDS epidemic, dating back to 1984, when there were almost no AIDS service organizations available,

and clinical trials for HIV medications were in their infancy.

"Now we have a wide range of HIV care and services organizations and a number of high-quality clinics for HIV, so we've come a long way," Foust notes. "But in rural places, where it's a long distance from where someone lives to a provider or physician providing HIV care, transportation is a big obstacle." Taxicabs and buses are usually either limited or unavailable, so if rural HIV patients don't have their own cars, then there may be no way for them to reach the HIV clinic and return home again, Foust adds.

North Carolina employs public health specialists who work with HIV providers, delivering information to HIV patients and providing transportation to physicians when it's feasible, Foust says.

"We have staff who spend all day taking one client to a doctor," Foust says. "Their average monthly mileage is over 1,300 miles a month from interacting with HIV patients and providing transportation."

Even finding a primary care physician can be a challenge in rural areas, particularly when patients do not have private insurance. Often, the only place such patients receive medical care is at the local health department or in an emergency room.

All of these challenges can only be solved by cooperation among state legislatures, funding sources, and federal partners, Foust says.

"There's much more our own states can do, and much more can be done at the community level," Foust says. "We have to own up to our responsibility, and we can't expect someone else to fix the problem for us, but at the same time we need help." ■

Dallas group builds a black MSM community

Outreach staff dress in burgundy fatigues

For an AIDS service organization to succeed in attracting an elusive and at-risk population, it must demonstrate that outreach workers care about the clients and accept them just as they are, according to a long-time HIV/AIDS activist who has succeeded where others have failed.

Renaissance III of Dallas recently opened the state's first community center for young African-American men who have sex with men (MSM), where they can take educational courses, receive leadership training, attend support group meetings, and engage in recreational activities, including movie nights, says **Don Sneed**, executive director of the organization.

"We have a computer lab and conduct history courses," Sneed says. "We have a whole array of services where we work with young people to help them become viable members of the American mainstream."

The center, which caters to African-American men ages 17-24, also provides health screenings and counseling on education, life skills, and psychosocial concerns. Renaissance III also participates in Ryan White Planning Council meetings, as well as community planning group meetings.

Fighting against isolation

"One of the things we do is give young men training about what these groups are and what they're able to do, and we help the youths be at the planning table when decisions and strategies are made," Sneed says. "We had one youth from our program who was selected to be on a National Youth Advocacy Coalition council, so we're making good progress."

In building a cohesive young MSM community, the organization's staff demonstrate that these young people are not isolated from the mainstream African-American community, Sneed says.

"It's important for them to understand how we are just as much a part of the fabric and fiber of the overall community as is Mr. John Doe down the street," Sneed says. "We do not support or endorse a situation where our young people who happen to be MSM need to be isolated, alienated, ostracized, or cut away from the African-American community, although that's the reality of being born gay and black in America."

Renaissance III's other efforts to reach and support at-risk African-Americans include these programs:

- **Social marketing campaign.**

The organization works to raise awareness of HIV/AIDS and human rights in the African-American community, primarily through programs on the local public access television station, Sneed says.

"We have three educational one-hour TV programs about HIV/AIDS on the local public access system, and we have had about 30 shows over the last four years," Sneed says. "This has gone a long ways toward sensitizing the overall African-American community to our own diversity and to HIV and AIDS."

Sneed, another staff member, and a youth served by the center each have their own talk show programs. For instance, one of Sneed's shows discussed HIV and AIDS in the African-American community and focused on how this is a health emergency and no one is exempt from the epidemic.

TV host gives living proof of second chances

"We had an epidemiologist from the county on there and HIV/AIDS service providers," Sneed says. "I, as an HIV-positive, African-American man who has sex with men, and ex-crack addict, am the show's host."

Sneed says his own status as someone who has been there, done that, and now copes with HIV, shows his audience that people can get a second chance if they apply themselves.

Also, Sneed's openness about his own situation helps to reduce the burden of stigma and shame that many HIV-positive people experience. For example, one African-American mother who is HIV-positive had experienced considerable guilt and shame about her disease. But after seeing Sneed's show, she contacted him to say that he had helped her develop enough courage to come down to the agency and ask for help in living successfully with her disease.

• Client advocacy program.

The organization helps clients receive the HIV/AIDS services they need, either through the center or through other organizations with whom the organization has special agreements.

Services include individual and group counseling, assisting clients with transportation to get to medical appointments, and HIV/AIDS treatment and services libraries in one of the center's five offices, Sneed says.

"Our program is available to African-American women, but 80% of the black people in Dallas who are infected with HIV are African-American men," Sneed says.

Renaissance III has one unique program that is very popular among its clients. It's called "Clothesline," and the program provides new clothing to clients at no charge, Sneed says.

"We just gave out brand-new winter coats for those who haven't gotten one in the last two years," Sneed adds.

Another program involves a partnership with the Texas prison system to help provide pre-release planning and post-release services for HIV-infected inmates, Sneed says.

Funding for the clothing program comes from annual fundraising efforts by the black gay and lesbian community, and the organization and its staff of 17 are funded by money from Ryan White, the Centers for Disease Control and Prevention in Atlanta, and the Texas Department of Health, Sneed says.

• Outreach efforts.

Renaissance III workers visit the African-American community in teams of two to three people each day and evening, promoting HIV education and prevention, Sneed says.

Outreach workers visit people in neighborhoods where crack is sold, in parks where married men meet other married men for sex, in nightclubs, at junior colleges, and in other places, Sneed says.

Dressed in burgundy and purple battle fatigue outfits, consisting of a hat, jacket, shirt, and pants, these workers, nicknamed "commandos," let people know there is a war against HIV and AIDS, Sneed says.

"We're not interested in who you are by day and that other person by night," Sneed says. "It's not relevant. What is relevant is there are certain things you can do to protect yourself and others, and if you get infected, you need to get help."

CE objectives

After reading this issue of *AIDS Alert*, CE participants should be able to:

• identify the particular clinical, legal, or scientific issues related to AIDS patient care;

• describe how those issues affect nurses, physicians, hospitals, clinics, or the health care industry in general;

• cite practical solutions to the problems associated with those issues, based on overall expert guidelines from the Centers for Disease Control and Prevention or other authorities and/or based on independent recommendations from specific clinicians at individual institutions. ■

The commandos are forceful with their prevention messages and are so strict with their confidentiality of people who come forward for help that they have gained respect in the community, Sneed adds.

"We have a whole series of marketing materials that are Afrocentric and which we distribute to folks," Sneed says. "We do this seven days a week, and now they see us coming and start running up to us, saying, 'Do you have any condoms today? What do you got for us?'"

• **Incentive-based programs.**

Sneed says he doesn't believe that some of the more traditional incentive programs of providing fast food coupons or theater tickets to people who are tested for HIV would work as well as Renaissance III's incentive program.

"When they come back for their HIV test results, they get their incentive, and that's why we have an 87% return rate for HIV test results," Sneed says.

Each person who is tested and returns for the results receives a new pair of tennis shoes or colorful urban boots, Sneed says. "We also offer incentives from our Clothesline program, including coats, shirts, sweaters, pants, dresses, skirts, socks, underwear, and personal hygiene kits."

The shoes and boots cost the organization between $7 and $11 per pair, and they help to build the community's trust in the organization because people know Renaissance III goes the extra mile for them, Sneed says.

"Black folks really understand if you care about us, and based on how you treat us, they respond positively," Sneed adds. "One thing that warms my heart is when we come to open our testing office and we have three to five people waiting at the door at 8:30 a.m. to take the HIV test." ■

CE/CME *directions*

To complete the post-test for *AIDS Alert*, study the questions and determine the appropriate answers. After you have completed the exam, check the answers **on p. 28**. If any of your answers are incorrect re-read the article to verify the correct answer. At the end of each six-month semester you will receive an evaluation form to complete and return to receive your credits.

CE/CME *questions*

5. Which of the following is NOT advice being given by experts concerning HIV/AIDS patients and the smallpox vaccine?
   A. Anyone who plans to volunteer to be vaccinated for smallpox should know their HIV status.
   B. Anyone who has close contact with a known smallpox case should be vaccinated, regardless of their HIV status.
   C. Those with advanced-stage HIV disease are probably more susceptible to incidental infection that early-stage patients, and many experts say the dividing line between the two is a CD4 count of less than 200/mm^3.
   D. There is no risk to HIV patients if their partners have the smallpox vaccination.

6. Optimal therapy for patients with compromised immune systems who develop progressive vaccinia include highly active antiretroviral therapy and vaccinia immune globulin.
   A. True
   B. False

7. Which region of the United States had the highest estimated AIDS incidence, prevalence, and growth in AIDS cases from the late 1990s to 2001?
   A. Midwest
   B. Northeast
   C. South
   D. West

8. When AIDS service organizations and public health officials attempt to reach African-American men who have sex with men (MSM) with prevention efforts, what is one of their biggest obstacles?
   A. The community has a high rate of denial about HIV/AIDS and is not receptive to prevention messages.
   B. Testing rates are low because there are too few HIV clinics in the areas most frequented by this population.
   C. Most of the available prevention messages are geared toward white MSM and are irrelevant to the African-American MSM community.
   D. African-American MSM typically do not present as a cohesive community, so before prevention messages and services can be offered effectively to this population, there needs to be some community building.

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PS Form **3526**, September 1998 *See instructions on Reverse)*

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e. Free Distribution Outside the Mail *(Carriers or Other Means)*			8	100
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I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

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3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
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5. In item 16, indicate date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form **3526**, September 1999 *(Reverse)*

CE/CME *answers*

Here are the correct answers to this month's CME/CE questions.

5. **D — There is no risk to HIV patients if their partners have the smallpox vaccination.**
6. **A — True**
7. **C — South**
8. **D — African-American MSM typically do not present as a cohesive community, so before prevention messages and services can be offered effectively to this population, there needs to be some community building.**